DEPARTMENT OF MANAGED HEALTH CARE

Mental Health Parity in California
Mental Health Parity Focused Survey Project

A Summary of Survey Findings and Observations

HMO Help Center
Division of Plan Surveys

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P R E F A C E

The California Department of Managed Health Care (DMHC) assisted in the development of resources and information for a preliminary analysis on mental health parity conducted by the Department of Mental Health (DMH). The DMH report was based on information from DMHC and various stakeholders obtained between January and March 2005. Many of these stakeholders have continued to meet and assist DMHC with the ongoing surveys and other activities reflected in this report. The DMH report restated some of the many long-standing issues about the practical difficulties of applying mental health parity that were presented in earlier studies and in DMHC findings, which are also included in this report.

Recommendations in the DMH report were based on DMH's experience with Medi-Cal and other public health programs that provide coverage for mental health services. To the extent that they are applicable, the results from the brief DMH assessment of mental health parity by health care service plans have been incorporated into this report and its recommendations.

E X E C U T I V E S U M M A R Y

Report Format

This report is divided into five sections:

Section I introduces the laws, regulations, and legislation that require mental health parity.

Section II contains an analysis of specific compliance deficiencies found in each of the four broad areas assessed by the survey:

1) Ensuring Access and Availability of Services
2) Benefits Administration and Managing Utilization of Services
3) Ensuring Continuity and Coordination of Care Among Providers
4) Oversight of the Specialty Mental Health Plans to Which Responsibilities Are Delegated

Survey findings showed that the plans had established policies and procedures, contracts, and Evidence of Coverage documents reflecting coverage of parity diagnoses[1] as defined in the Parity Act under the same terms and conditions applied to other medical conditions.

Plans have developed programs to expand and improve services for enrollees with parity diagnoses, including programs to improve continuity and coordination of care, and to promote access to services for enrollees in minority linguistic and cultural groups.

Section III, Part A, discusses observations regarding access for children with pervasive developmental disorders. The plans vary in their approach, thus creating confusion in three areas:

1) Initial evaluation of children with autism
2) Authorization and management of prescribed therapy and medications
3) Authorization and management of speech and language therapy (SLT) and occupational therapy (OT)

Section III, Part B, provides a high level summary of key issues impacting the implementation of Assembly Bill 88 (AB 88), the performance of health plans offering mental health services in California, and selected recommendations to address those issues.[2]

Section IV, Best Practices provides examples of practices and programs that were especially innovative in addressing challenges to providing mental health services. Individual plans meeting minimum compliance requirements may benefit from evaluating and gathering ideas from stronger programs. The program

[1] See Appendix F for a list of severe mental illnesses in a person of any age, and serious emotional disturbances of a child, which are termed "parity diagnoses."
[2] See Appendix E for a detailed discussion of the issues impacting mental health parity.

descriptions could serve as models for plans considering how to better meet the needs of enrollees.

Section V, Recommendations, is divided into two categories:

1) Recommendations to the DMHC
2) Recommendations to Health Plans

The findings of the Parity Focused Surveys provide information of interest not only to the principals (health plans and the DMHC), but also to enrollees, mental health advocates, policy makers, the business community, and payors.

Background

In 1999, the California Legislature enacted AB 88, which required private managed health insurance plans to provide coverage for the diagnosis and treatment of severe mental illness in a person of any age, and coverage of serious emotional disturbances in a child, under the same terms and conditions applied to other medical conditions. Health and Safety Code section 1374.72, often referred to as the Parity Act, contains the specific requirements of AB 88.

The DMHC regulates and monitors licensed private health plans in California under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene or the Act), which includes monitoring compliance with the Parity Act. Accordingly, in 2005 the DMHC conducted a "focus" survey[3] of seven large health plans to evaluate compliance with the Parity Act, to identify the challenges of implementation from the plans' perspective, and to investigate problems voiced by the public, the Legislature, and stakeholders.

Collectively, these seven plans provide coverage to approximately 85 percent (16 million consumers) of California's commercial managed care population. They also represent the full range of delivery models that plans use to provide mental health services. (See Appendix B – Overview of Mental Health Delivery Systems.)

A key objective of the Parity Act is to eliminate previous benefit limits imposed on the treatment of mental health conditions that make those benefits less comprehensive than physical health

[3] Based on concern raised by consumer stakeholders, providers, health plans, legislators, or regulators, a "focus" survey may be used to target a particular area(s) of health care delivery, reviewing pertinent issues and requirements with health plans. In this case, legislators and consumers questioned whether parity between medical and mental health care had been achieved. Under the mental health parity law, plans must ensure that the diagnosis and medically necessary treatment of mental health conditions are covered under the same terms and conditions that are applied to other medical conditions.

benefits (such as higher co-payments and deductibles, and limits on the number of outpatient visits). The survey results did *not* identify disparities between the contractual terms and conditions used for medical versus mental health coverage, as disclosed in the Evidence of Coverage (EOC). Further, the survey found no pattern of plans denying services for mental health conditions that would be covered for other medical conditions.

Methodology

The DMHC assembled a multidisciplinary project team, which developed a standardized review protocol to ensure a thorough examination of the seven plans' performance on all aspects of the Parity Act. The team's surveyors used the protocol to review each plan's performance in four broad areas:

1) Ensuring Access and Availability of Services
2) Administering Benefits and Managing Utilization of Services
3) Ensuring Continuity and Coordination of Care Among Providers
4) Oversight of Specialty Mental Health Plans to Which Responsibilities Are Delegated

The team identified fourteen broad issues in the mental health delivery system that pose challenges for the health plans. The top five challenges are listed below. (See Section III B "Issues Impacting Mental Health Parity" for a comprehensive list.)

1) A lack of clarity regarding the distribution of responsibilities among plans, regional centers, and school systems for the diagnosis and treatment of children with autism-related disorders.
2) A lack of consistency in the nature and levels of case management services provided by the plans.
3) A shortage or uneven geographic distribution of behavioral health professionals, especially of child and adolescent psychiatrists, which causes delays and frustration for enrollees seeking appointments.
4) Inconsistency among plans in providing emergency care instructions to enrollees and in the operation of after-hours services.
5) Significant variations in coverage, access, and quality of services offered by residential treatment centers.

Findings

The survey findings showed that the plans have established policies and procedures, contracts, and EOC documents that correctly require that mental health parity diagnoses be covered under the same terms and conditions as other medical diagnoses. The plans have also developed programs to expand and improve services, such as continuity and coordination of care for enrollees with mental health parity diagnoses, and to promote access to services for enrollees in minority linguistic and cultural groups.

The survey identified several aspects of compliance with the requirements of the Parity Act that are problematic for the health plans. Among the most common problems:

- ☑ Payment of Emergency Room (ER) Claims
- ☑ Monitoring Access to After-Hours Services -- the lack of plan monitoring to ensure that provisions for after-hour services are reasonable and that providers respond to enrollee messages in a timely manner
- ☑ Clear and Concise Explanations in Denial Letters

Because of the DMHC Surveys, the plans have implemented changes in operations resulting in:

Expanded after-hours access monitoring to ensure that consumer calls for help are answered and handled, and that emergency information is provided

Established and published standards for ensuring that enrollees have access to after-hours care from providers.

Improved handling and approval processes for ER mental health claims.

Clarified wording in denial decisions issued to both the requesting provider and the enrollee.

Corrective Action

As a result of the survey findings, the DMHC immediately required the plans to implement corrective actions to bring them into compliance with the Parity Act. (See Appendix A - Survey Methodology.) Accordingly, the plans made the following changes in their operations to improve enrollee access to mental health services:

- ☑ Expanded after-hours access monitoring to ensure that consumer calls for help were answered and handled, and that emergency information was provided. These efforts included monitoring access to psychiatrists, as well as to non-psychiatric therapists, thereby providing enrollees with more options for assistance.
- ☑ Established and published standards for ensuring that enrollees have access to after-hours care from providers. Specific standards include providing an answering machine with the provider's emergency contact information, an emergency exchange service to connect the enrollee to a provider quickly, or instructions on how to seek emergency care from facilities in the area.
- ☑ Changed telephone call response procedures to ensure that enrollees inquiring about mental health benefits received

accurate information on their after-hours treatment options under the Parity Act.

- ☑ Improved handling and approval processes for ER mental health claims. (This is important because incorrectly denying mental health care benefits may create a barrier to future services, which may be based on previously denied payments, or on the inappropriate billing of enrollees for services.)
- ☑ Clarified the wording in denial decisions issued to both the requesting provider and the enrollee. Providing clear information regarding benefits to which the enrollee is entitled and/or the limitations or exclusions of benefits prevents delays in obtaining needed services.
- ☑ Required providers to give the name and phone number of the mental health professional making a medical necessity denial decision. This is essential so that the treating provider can contact the correct person at the plan to discuss the decision, and provide any additional information necessary for facilitating needed care.

Conclusion

The surveys gave the DMHC an opportunity to conduct a broad systems evaluation among the plans. The system problems stemmed from variations in plan' interpretations of legislative requirements and coverage responsibilities; the challenges of coordinating care among a myriad of payors, providers, and agencies; and systemic gaps and deficiencies in the health care system. The input and cooperation of the plans, consumers, advocacy groups, educators, healthcare providers, regional centers, and state agencies was invaluable.

Recommendations

The following table lists recommendations based on the work completed by DMHC staff on the mental health parity project. Further detail on each recommendation, along with proposed actions, is included in Section V.

Recommendations to the DMHC	
1	Form a State agency collaborative work group.
2	Continue stakeholder forums.
3	Assess and clarify regulations for after-hours services and denials.
4	Enhance consumer information on the DMHC website.
5	Continue oversight of mental health related grievances and Independent Medical Review (IMR).
6	Coordinate a consumer education program.
7	Research and report – plan reimbursements to public agencies.
8	Establish a work group with representation from CAHP, health plans, providers, consumers, emergency services and DMHC regulators to discuss alternatives and improvements in mental health delivery systems.
Recommendations to the Health Plans	
9	Review and update emergency room claims payment policy.
10	Investigate consumer concerns regarding phantom networks.
11	Institute systems to ensure accountable coordination of care.
12	Eliminate barriers to coordination of services and improve communications between health plans in mental health “carve out” arrangements.
13	Address payment issues with public agencies providing services to health plan enrollees.

I. INTRODUCTION

The DMHC is charged with monitoring health plans' compliance with Health and Safety Code section 1374.72, often referred to as the Parity Act, which requires full-service health plans to provide coverage for the diagnosis and treatment of the severe mental illness (SMI) of a person of any age, and of the serious emotional disturbance (SED) of a child, under the same terms and conditions applied to other medical conditions.

DMHC Director Cindy Ehnes directed the Plan Surveys Division of the HMO Help Center to design focused surveys to review health plan compliance with enacted mental health parity laws. The project began in November 2004.

The corresponding title 28 of the California Code of Regulations section (Rule) 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Rule 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans, and to ensure continuity and coordination of care.

AB 88 requires health plans to eliminate the benefit limits imposed on the treatment of mental health conditions (e.g., higher co-payments and deductibles, limits on the number of covered outpatient visits or inpatient days). These benefit limits historically had made mental health benefits less comprehensive than physical health benefits. This expansion of mental health benefits was designed to enhance access to and improve the quality of mental health services for people with SMI and SED.

Mental health conditions covered under AB 88 include:

- ☑ SMI, which includes schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorders or autism, anorexia nervosa, and bulimia.

- ☑ SED of a child, other than a primary substance abuse disorder or developmental disorder, that results in behavior inappropriate to the child's age, according to expected developmental norms.

In 2004, DMHC Director Cindy Ehnes directed the Plan Surveys Division of the HMO Help Center to design focused surveys to assess health plan compliance with enacted mental health parity laws, and to address consumer concerns such as inadequate access

to mental health providers and coverage of emergency mental health services. The project included three phases:

1) Holding stakeholder meetings and facilitating ongoing dialogue with the mental health community
2) Developing survey tools, and plan selection and scheduling procedures
3) Conducting Mental Health Parity Focused Surveys of seven large health plans in accordance with plan-specific mental health delivery systems, e.g., integrated models or carve-out plans

In preparation for the on-site focused surveys, the seven plans responded to DMHC's preliminary questionnaire, and submitted an overview of plan operations, policies, and procedures. On the first day of the focused survey, each plan presented its assessment of challenges posed by the parity law.[4]

[4] See Appendix A for additional information on survey methodology.)

II. SURVEY FINDINGS

PLAN COMPLIANCE DEFICIENCIES IN FOUR MAJOR AREAS OF REVIEW

The focused surveys found that compliance problems specific to the Parity Act and other related Knox-Keene requirements were concentrated in two of the four major areas of review:

1) **Ensuring Access and Availability of Services**
2) **Benefits Administration and Managing Utilization of Services**

The following table lists the deficiencies in these two areas.

Most Common Compliance Deficiencies	
Ensuring Access and Availability of Services	Plans do not monitor to ensure that providers' provisions for after-hours services are reasonable and that providers respond to enrollee messages in a timely manner. (Five plans)
Benefits Administration and Managing Utilization of Services	Plans incorrectly deny payment for emergency room claims. (Six plans) Plans do not include all required information in denial letters; specifically, the plans do not: 1) Clearly and concisely describe the clinical reasons and criteria used in making medical necessity denial determinations. (One plan) 2) Clearly explain the reason for termination of services for children who are potentially SED and the process by which the plan refers these children to county mental health systems for evaluation. (One plan) 3) Consistently provide the name and phone number of the mental health professional who made the medical necessity denial determination. (Five plans)

Ensuring Access to and Availability of Services

Plans are required to develop adequate networks, monitor the availability of appointments and services, and show enrollees how to access services. The survey team found deficiencies in this area to be the second most frequent among the seven plans surveyed. The table below describes the access and availability deficiencies:

Plan Deficiencies Related to Ensuring Access to and Availability of Services
Plans do not monitor to ensure that providers' provisions for after-hours services are reasonable and that providers respond to enrollee messages in a timely manner. (Five plans)
Plans do not clearly present the differences between benefits available for parity conditions vs. those available for non-parity conditions when enrollees call the plan to obtain benefit information or to access services. (Two plans)
The plan does not ensure that enrollees have timely access and ready referral to routine mental health appointments. (One plan)
The plan's written policy does not correctly describe its obligations to provide coverage for the diagnosis and treatment of a person of any age with pervasive developmental disorders or autism. (One plan)

Provider Survey Findings:

Less than half gave after-hours emergency instructions

Less than half returned calls within 24 hours of receiving a message during business hours

After-hours Access to Providers, and Provider Responsiveness

Plans and their providers are required to timely respond to enrollees' after-hours needs and messages. Plans (or their associated mental health plan delegates) provide a 24-hour line so that enrollees can obtain referrals for appointments and can access triage services, crisis intervention, counseling, emergency care, or hospitalization, as appropriate. Once therapy is initiated or established, however, an enrollee typically contacts the provider directly, rather than contacting the plan. For this reason, enrollees must have after-hours access to individual providers, and clear instructions for contacting providers and/or obtaining other emergency assistance.

Many mental health providers are in solo practice, conducting counseling sessions during the day without office staff, making it necessary for enrollees to leave phone messages. The provider's timely response to messages is critical for ensuring that enrollees have access to services, particularly for scheduling initial appointments in an urgent situation.

After normal business hours, when the provider is not available to handle urgent/emergent situations, it is vital that the provider's voice mail provide clear information to callers about how to access needed services. For example, the caller may be instructed to call 911, a crisis hotline, a provider's cell phone number, or the provider's answering service.

To evaluate how quickly providers returned calls, and whether their voice mail messages included instructions about what to do in an urgent situation, the survey team called several provider offices both during and after normal business hours.

The survey team found that, on average, more than half of the providers surveyed provided information to the caller about what to do in an emergency or urgent situation occurring after normal business hours, and more than half of providers' voice mail messages contained either 911 or other emergency information. When the survey team left a voice mail message requesting a return call, almost half of the providers failed to return the call within 24 hours.

In addition to identifying the weaknesses in individual provider responsiveness, the survey showed that six of the seven plans had not established an effective system for monitoring provider messages to ensure that emergency instructions and coverage were adequate, and that providers returned calls within a reasonable period of time.

As a result of these findings, the DMHC required these six plans to:

- ☑ Distribute instructions to providers regarding after-hours coverage and messaging.
- ☑ Establish a system for monitoring the presence and appropriateness of the providers' messages and the timeliness of responses.

Presentation of Parity and Non-Parity Benefit Information

In many instances, the enrollee's member identification card contains a toll-free telephone service number for confirming eligibility and obtaining mental health benefit information and provider referrals. For callers who are in minimal distress and do not appear to have complicated treatment needs, the plan may provide information for outpatient mental health services based on the enrollee's stated needs and requests. For more complicated or urgent needs, the plan will transfer the enrollee to a higher-level licensed mental health clinician for triage and referral.

Two of the seven plans surveyed provided mental health parity benefit information only when prompted by an enrollee's or provider's specific request, or another indication that a parity-related condition was the focus of treatment, and thus the enrollee received information about parity benefits typically through the higher-level clinical crisis team members or care managers. Without clear and accurate information about their benefits, enrollees in these plans were unaware that expanded benefits are available to individuals with parity diagnoses.

As a result of these findings, the DMHC required these plans to do the following:

- ☑ Accurately and clearly describe parity and non-parity benefits to *all* enrollees inquiring about treatment.
- ☑ Train staff to present both parity and non-parity benefit information to enrollees.

Additional Findings Related to Access

As part of the provider telephone survey, the survey team verified that the provider was accepting new patients, and if so, when the next appointment for an initial visit would be available. On average, the seven plans provided initial appointments within 14 days of the call most of the time. However, one plan met this standard only half of the time, and less than half of the time for routine return or follow-up appointments.

Under the Parity Act, health plans are required to provide coverage for certain mental health conditions, including autism and related pervasive developmental disorders (PDDs), equal to the coverage provided for other medical conditions. The written policy of one

plan surveyed stated, "The *cornerstone* (emphasis added) of service access and provision throughout the life span of a member with autism and related PDDs are the regional centers or Early Intervention Centers. Children under the age of three and individuals past school age are the *sole responsibility* (emphasis added) of the Early Intervention Centers or regional centers."

Although these statements are in violation of the Parity Act, plan staff indicated that, in practice, the specialty mental health plan provides the full range of evaluation and ancillary services through the Early Intervention Centers or the regional centers whenever these services either are not available or parents choose not to access them.

As a result of these findings, the DMHC required these plans to do the following:

- ☑ Implement a corrective action plan and provide evidence of improvement in providing enrollee access to routine mental health appointments.
- ☑ Revise plan policy to clearly describe its responsibility to provide the full range of services to children with a PDD and/or autism, and to implement auditing procedures for verifying compliance with the Parity Act
- ☑ Educate staff about plan obligations

Benefits Administration and Managing Utilization of Services

The greatest number of compliance deficiencies occurred in the area of administering benefits and managing utilization of services.

The Parity Act requires that plans provide benefits for mental health services "under the same terms and conditions applied to other medical conditions." The survey team reviewed the plans' processes for authorizing mental health services and handling claims for enrollees with parity diagnoses. The review focused on claims for emergency services, in part due to the concern voiced by stakeholders that claims for emergency and other crisis intervention services were not being paid or covered, particularly for out-of-network services.

The survey team noted that although deficiencies relating to administration of benefits and management utilization are not violations of the Parity Act, they are violations of other Knox-Keene Act requirements in sections 1367.01, 1368, and 1371, which pertain to both parity and non-parity services. Nonetheless, they are included as deficiencies in this report because they generally affect the prior authorization of mental health services and 100% payment of emergency service claims, and as a result, affect the overall administration of benefits and management of services provided to enrollees with parity diagnoses.

Plan Deficiencies Related to Benefits Administration and Managing Utilization of Services
Plans incorrectly deny payment for emergency claims. (Six plans)
Plans do not include all required information in denial letters; specifically, the plans do not: 1) Clearly and concisely describe the clinical reasons and criteria used in making medical necessity denial determinations. (One plan) 2) Clearly explain the reason for termination of services for children who are potentially seriously emotionally disturbed and the process by which the plan refers these children to county mental health systems for evaluation. (One plan) 3) Consistently provide the name and direct phone number of the mental health professional who made the medical necessity denial determination. (Five plans)

Incorrect Denial of Emergency Services

The survey team reviewed samples of case files and claims payments to assess benefit coverage decisions and authorization practices. More than half of the claims received from six of the plans involved incorrect denials of emergency room services. Incorrect denials tended to occur most frequently in claims received from facilities that were not a part of the plan's network, particularly claims from county mental health facilities. The problem was exacerbated when plans contracted mental health services of a specialty subsidiary or a managed behavioral

health organization (MBHO). Plans had difficulty determining whether the full service or the specialty mental health plan was financially responsible for certain services when an enrollee with both medical and mental health problems went to an ER. Finally, while plans had established internal policies stating that preauthorization and/or medical review is not required for payment under certain circumstances, these policies were not consistently applied, resulting in claims that were denied multiple times and appealed before plans eventually paid.

As a result of these findings, the DMHC required these plans to do the following:

- ☑ Implement immediate corrective actions, including internal audits, to monitor compliance with ER claims processing policies and procedures.
- ☑ Report audit results to the DMHC on a periodic basis. The DMHC will evaluate and provide feedback to plans on any further corrective actions.

Incomplete Denial Letters

When a plan denies a service, it must issue a denial letter to the enrollee and provider clearly explaining the reasons for the determination and provide contact information for enrollees and providers who may want to appeal. (Knox Keene Act section 1367.01 (h)(4)) To assess the quality and completeness of this documentation, the survey team reviewed cases in which services were denied, and found that one plan did not consistently describe clinical reasons and criteria used for medical necessity denial determinations in a manner that the enrollee could understand. Five of the plans did not always include the name and phone number of the clinician who denied the services. One plan did not clearly explain the reason for termination of services for potential SED children and the process by which the plan then refers them to county mental health systems for evaluation.

As a result of these findings, the DMHC required these plans to do the following:

- ☑ Make revisions to template letters to include all required information.
- ☑ Conduct audits to verify improvements in performance, with follow-up by the DMHC to confirm improvement.

Ensuring Continuity and Coordination of Care

Enrollees with complicated conditions may require services from multiple mental health providers. In addition, mental health needs must be addressed concurrent with medical needs in some cases. For example, children with autism may require services from a physician, psychologist, speech therapist and regional center. Consequently, the Parity Act requires the full service health plan to ensure continuity and coordination of care across the health care network, and to monitor the collaboration and exchange of information between medical and mental health providers.

The most effective way to accomplish this appears to be through case management, which is the structured process by which care and benefits are coordinated for cases that require a variety of services from multiple providers. A case manager works with mental health and medical providers and the enrollee/family to develop a plan of treatment, identify funding sources, and facilitate communication among the various parties. The deficiencies described below involved a lack of structured case management for individuals with complicated conditions.

Plan Deficiencies Related to Continuity and Coordination of Care Among Providers
The plan does not have a structured approach for monitoring the continuity and coordination of care that enrollees receive in the outpatient setting and for identifying individuals who could benefit from structured case management. (One plan)
The plan does not effectively monitor and improve the exchange of information among medical and mental health providers. (One plan)

Case Management Programs and Sharing Medical Information

The survey team reviewed the plans' mechanisms for ensuring continuity and coordination of care, as well as for monitoring the exchange of clinical information between providers.

One plan did not have criteria for determining case management referrals, such as multiple hospital admissions, or the ability to identify and ensure adequate treatment of enrollees with co-existing medical disorders. Mental health case management staff did not work directly with their peers on the medical staff, or contact a medical provider to assure follow-up of medical issues.

Another plan provided case management in a very small number of extremely complicated cases, but did not provide case management services to facilitate coordination of care between mental health and medical personnel for less severely impaired individuals.

As a result of these findings, the Department required these plans to:

- ☑ Identify enrollees who would benefit from case management and monitor the continuity and coordination of care received by enrollees throughout the health care network.
- ☑ Implement a system to facilitate communication and coordination of care between mental health and medical providers.

Managing the Performance of Specialty Mental Health Plans

The Parity Act requires a full-service plan to monitor the performance of a contracted mental health specialty plan for compliance with the law. The full-service plan retains ultimate responsibility for the care provided by the delegated plan, and for ensuring its compliance with all relevant standards related to access and availability of services, continuity and coordination of care, and administering benefits and managing utilization of services. The survey team identified no deficiencies in this area.

III. SURVEY OBSERVATIONS

The Survey Project afforded the DMHC a unique opportunity to explore other aspects of the mental health delivery system and engage in dialogue with health plans whose business is to facilitate the delivery of services. The Survey Team requested plan perspectives on the challenges they faced in implementing the Parity Act. During the time that the Survey Team was on-site at the health plans, interviews and discussions with various plan staff involving the plan perspective and stakeholder concerns resulted in valuable information for this report.

ACCESS FOR CHILDREN WITH PERVASIVE DEVELOPMENTAL DISORDERS

There is confusion about the relative responsibilities of the health plans and the regional centers.

Federal programs also provide early intervention services for children under age three. Hence, the enrollee may choose between a public program or private coverage.

Consumer and industry stakeholders have raised concerns about a perceived limitation or lack of coordination of care in mental health services to children with autism and other PDDs. Three service entities have responsibility for diagnosing and providing services to children[5] with autism-related disorders -- the health plans, the public school system (under Part B of the Individuals with Disabilities Education Act (IDEA[6])) and the regional centers (under the Lanterman Developmental Disabilities Services Act and Part C of IDEA).

The responsibilities of each system vary depending upon the age of the child. For example, for children under the age of three, the regional centers and health plans share responsibility. For older children, the public school system becomes the responsible party, and regional center responsibility diminishes.

[5] Note that in theory, some of these coverage issues affect adults as well as children; however, they are not as problematic for adults because the relevant services (occupational therapy, speech and language therapy, and applied behavioral analysis therapy) are rarely, if ever, considered "medically necessary" or appropriate for an adult.

[6] The IDEA is the nation's special education law. First enacted three decades ago, the IDEA provides billions of dollars in federal funding to assist states and local communities in providing educational opportunities for approximately six million students with varying degrees of disability who participate in special education. Part A of the IDEA contains the general provisions, including the purposes of the IDEA and definitions. Part B, the most frequently discussed part of the IDEA, contains provisions relating to the education of school-aged and preschool children, the funding formula, evaluations for services, eligibility determinations, Individualized Education Programs (IEPs) and educational placements. It also contains detailed requirements for procedural safeguards (including the discipline provisions), as well as withholding of funds and judicial review. Part B also includes the Section 619 program, which provides services to children aged three through five years old. Part C of IDEA provides early intervention and other services for infants and toddlers with disabilities and their families (from birth through age 3). These early intervention and other services are provided in accordance with an Individualized Family Service Plan developed in consultation between families of infants and toddlers with disabilities and the appropriate state agency. Part C also provides grants to states to support these programs for infants and toddlers with disabilities. Part D provides support for various national activities designed to improve the education of children with disabilities, including personnel preparation activities, technical assistance, and special education research.

Confusion about the relative responsibilities between the health plan and the regional centers[7] is also a reality. For children under age three, federal laws governing early intervention services make utilization of an enrollee's health benefit plan voluntary. This is inconsistent with AB 88, which holds plans accountable for making services available to all ages.

Lastly, plans vary in approach to service delivery for PDD in three areas:

1) Initial evaluation of children with autism
2) Authorization and management of prescribed therapy and medication
3) Authorization and management of SLT and OT

The findings below evidence the confusion regarding assumed responsibilities between health plans and regional centers, and for school-aged children with autism-related disorders, the public school system as well.

Initial Evaluation of Children with Autism

Plans vary in their handling of services for autistic children. Enrollees may seek services for an autistic child or adult through the regional center and/or school system. If parents report difficulty in obtaining services from the public sector, the health plans will provide them.

Some plans stated that they do not require the enrollee to seek evaluative and treatment services from the public sector, but admit to educating (and encouraging) enrollees about services available from the public sector, "to take advantage of services that are not otherwise covered by the plan," such as support groups, research participation and applied behavioral analysis therapy (ABA).

Plans administering benefits for the Healthy Families program (HF) encourage enrollees to seek services from the regional centers. If parents of HF children suspected to have autism request referral to the private sector, the plan instructs them to ask the Primary Care Provider (PCP) for a referral.

[7] Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and support for individuals with developmental disabilities. California's 21 regional centers have over 40 offices throughout the state to provide a local resource to help find and access the services available to individuals and their families.

The fully integrated[8] health plan that has its own developmental pediatricians and psychologists who provide evaluative and treatment services neither refers enrollees to the regional centers nor points them toward the public sector. However, it accepts the results of evaluations from a regional center, as well as referrals from any provider in the system, although most referrals for younger children come from pediatricians. Parents can also call the psychiatry department to request an evaluation without first obtaining a referral.

Authorization and Management of Prescribed Therapy and Medications

The survey team found variations in the seven plans surveyed in approach and responsibility for services extending to the area of authorization and management. One plan stated that medication management was the responsibility of the psychiatrist. Several plans required prior authorization for continued therapy and medical management services for children with autism once a diagnosis was established. There were other cases in which the plan required authorization for any services in the prescribed treatment plan not provided by the regional center or the public school system. When additional resources needed for the treatment of autism went beyond those provided by the benefit plan, care managers encouraged enrollees to seek public advocacy assistance to obtain services through schools or regional centers, as appropriate.

Authorization and Management of Speech and Language Therapy and Occupational Therapy

A few health plans or contracted capitated medical groups were responsible for authorizing SLT and OT once diagnosis of autism and other related PDD was established. However, according to plan staff members, the plan's nurse case manager, rather than the medical group, usually handled requests for these services.

Plans operating under a "carved out"[9] model stated that SLT and OT are the financial responsibility of the full-service plan and that enrollees have open access without the need for authorization

[8] Integrated Model - The full-service plan utilizes a group of employed mental health providers co-located or closely linked with the medical providers within the delivery setting. Both the medical and mental health providers belong to a multi-specialty group either employed by or contracted with the health plan. An example of this model is Kaiser Foundation Health Plan, Inc.

[9] Carved Out Model - The full-service plan contracts with a MBHO, a specialty plan. The full-service plan may retain certain financial risks for select services such as out-of-network and out-of-area mental health services.

based on referral by their PCPs. It is not necessary for the full-service plan's case manager to become involved in arranging these covered therapies. However, in situations where the specialty mental health plan's case manager perceives the enrollee as being compromised in his/her ability to access these services directly, that case manager will call the full-service plan's case manager to arrange the transfer of care.

Under a subsidiary model,[10] one plan stated that 90 percent of its enrollees belong to capitated medical groups that are financially responsible for SLT and OT; hence, they are responsible for authorizing services. The plan's utilization management (UM) department authorizes services for the remaining ten percent of enrollees.

Another plan operating under the subsidiary model stated that SLT and OT were covered under physical/medical health benefits; therefore, enrollees access these services directly through the full-service plan. In practice, this requires enrollees to seek services through the full-service plan's capitated medical groups, which have financial responsibility and to which the plan has delegated UM. Hence, the medical groups are responsible for authorizing these services.

Under the integrated model, trained therapists provide SLT and OT services for children with autism within its care system. The case manager can order these therapies and coordinate the plan's services with services that the child may concurrently be receiving at the regional center and/or the public school system.

ISSUES IMPACTING MENTAL HEALTH PARITY

Five years after the implementation of AB 88, the provision of mental health parity services has resulted in significant structural and operational changes within health plans and their networks of service providers. This section of the report summarizes survey observations, reporting on issues impacting mental health parity. These issues fall into three broad categories:

1) Parity-specific issues stemming from the AB 88 legislation
2) The challenges of coordinating care among a myriad of payors, providers, and agencies
3) Systemic gaps and deficiencies of the healthcare system

[10] Subsidiary Model - The full-service plan contracts with a subsidiary that specializes in mental health services. A subsidiary need not be exclusive to the full-service plan. It may be an MBHO that contracts with other health plans or with employer groups. The subsidiary recruits and maintains its own network of mental health providers.

Within these three broad categories are 12 far-reaching issues, summarized below.[11]

Table 1

1) Parity-Specific Issues Stemming from AB 88 Legislation

a. Coverage of only a partial list of mental health diagnoses results in definitional and diagnostic challenges.
b. There is a lack of clarity regarding responsibility for the diagnosis and treatment of autism-related disorders.
c. Exclusion of parity-level coverage for substance abuse impedes the treatment of enrollees with a dual diagnosis of mental illness and substance abuse.

2) The Challenges of Coordinating Care among a Myriad of Payors, Providers, and Agencies

a. The plans vary significantly in programs and strategies aimed to: (1) ensure continuity and coordination of care between the medical and mental health sectors, and (2) identify and ensure appropriate treatment/referral for mental health conditions in the primary care setting.
b. The nature and levels of case management services vary markedly across health plans.
c. The division of financial responsibility arrangement between full service and specialty plans complicates case coordination and management.
d. Significant variation occurred in the plans' capacity to ensure accurate and timely payment of emergency room claims.

3) The Health Care System - Systemic Gaps and Deficiencies

a. Significant variation occurred in coverage, availability, and quality of services offered by residential treatment centers. As a result, services are inconsistent across plans.
b. There are an insufficient number of structured programs for the treatment of eating disorders, especially for children and young adolescents.
c. A significant shortfall and misdistribution of the behavioral health workforce exists in California, especially with regard to child and adolescent psychiatry.
d. Experiences with "phantom* providers/phantom networks" have resulted in delays and frustration for enrollees seeking appointments.
e. There is inconsistency in plan interpretation of requirements and associated plan operations in support of after-hours services and emergency care instructions.

**The term "phantom providers" (also "phantom network") is used to describe a situation where availability of providers is not as represented by the plan. When enrollees contact some providers listed in the provider directory, they find that these providers are not taking new patients.*

[11] See Appendix E for a detailed discussion of each issue.

IV. BEST PRACTICES

PRACTICES DEVELOPED TO ADDRESS THE CHALLENGES OF PARITY

The survey team noted a number of practices and programs that were especially innovative in addressing various challenges in providing mental health services. The following program descriptions may serve as models for plans seeking to better meet the needs of enrollees.

The survey team noted a number of industry "best practices" in the following areas:

Cultural/Linguistic Programs

Coordination of Care

Ease of Access

Cultural/Linguistic Programs[12]

Plans reward staff members and providers who become certified in language competency. Those who have been certified wear buttons to identify themselves to enrollees who may require assistance with translation.

Most of the surveyed plans have developed a variety of approaches to help enrollees with specific linguistic and cultural needs understand and use their services. These approaches include:

- ☑ Hiring customer service staff who are competent in languages other than English
- ☑ Listing languages spoken by each provider in provider directories, and asking enrollees who call for referrals whether they prefer a provider who speaks a particular language
- ☑ Providing translation services for providers and customer service personnel
- ☑ Providing information, including health education materials, web site information, grievance documents, and other member materials, in languages commonly used by plan enrollees
- ☑ Offering and/or requiring training for staff and providers in cultural sensitivity and linguistic competency
- ☑ Monitoring patient satisfaction and complaint data for cultural/linguistic issues

[12] Some of the practices noted in this section may be required by the Access to Language Assistance regulations (Rule 1300.67.04), which are under development by the Department.

Coordination of Care

To increase collaboration with regional centers for treatment of autism-related disorders, some plans have created specialist case management positions. These case managers are able to develop increased understanding and expertise about the responsibilities of schools in providing services to children with autism as part of the individualized education program.

At one of the mental health plans, one case manager in each of the regional Patient Management offices facilitates coordination of case management services and screens enrollees identified by the plan as potentially having a co-morbid mental health condition. This case manager also serves as a "behavioral health subject matter expert" for the plan and helps enrollees get referrals to mental health care services, which includes obtaining the member consent necessary for coordination of care.

Another of the plans assigns a primary therapist the responsibility of managing all aspects of a patient's care, coordinating the efforts of a multidisciplinary treatment team.

Ensuring Ease-of-Access

Primary care physicians treating patients with dual diagnoses have immediate access to a psychiatric consult. Such programs help offset access problems to psychiatric providers in the network and promote real-time collaboration among medical and psychiatric specialties. Collaborative efforts between health plans are encouraged to ensure that there is sufficient call volume to support the psychiatry time necessary for providing a timely psychiatric consultation.

Plans regularly monitor appointment availability through the following activities:

- ☑ Verifying that providers are accepting new patients
- ☑ Closely monitoring whether enrollees who are unable to get an appointment with a provider call back for additional referral names
- ☑ Monitoring enrollee complaints

Making the mental health plan, rather than the full service plan, financially responsible for these services facilitates access to SLT and OT.

One plan allows enrollees to access services directly, without first going through an intake process, and then pays for all first visits. This reduces two potential barriers to access: 1) the necessity of going through the extra step of intake when seeking help, and 2) cost. Reimbursement for subsequent visits is based on the provider's diagnosis, and whether it is named in the parity law versus a diagnosis that is not covered. If the provider decides that further care is needed, the plan eliminates visit limits for enrollees.

Ensuring Ease of Access to Emergency/Urgent Care

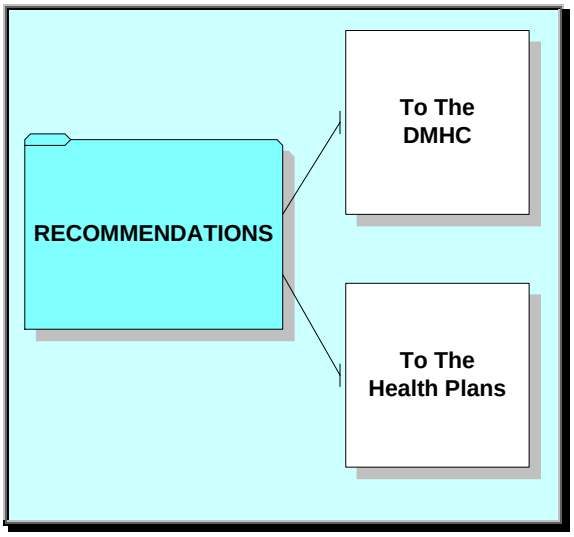
Some plans contract with a small number of providers to reserve appointment slots for emergencies, creating a readily available number of open appointments. The 24-hour intake staff can then use these openings for urgent need or emergency cases.

V. RECOMMENDATIONS

PROPOSAL FOR ONGOING EFFORTS TO IMPROVE SERVICE DELIVERY

The DMHC's Mental Health Parity Survey Project relied heavily on input from industry and consumer stakeholders to focus attention on particular areas of the mental health services delivery system.

This summary report represents a unique opportunity for the DMHC to analyze and support improvement in mental health care services to Californians. The analysis, based on stakeholder concerns, has also become a vehicle for recommendations.



These recommendations are divided into two categories – recommendations for the DMHC and; recommendations for health plans about providing information and assistance to enrollees suffering from mental illness.

Recommendations to the DMHC

RECOMMENDATION 1	**FORM A STATE AGENCY COLLABORATIVE WORK GROUP**

Form an Inter-Agency Collaborative Work Group Between the DMHC, the Department of Education, the Department of Mental Health, the Department of Developmental Services, and the Department of Insurance.

Proposed Actions

Define respective roles, service, and financial responsibilities of:

- Health Plans
- Regional Centers
- County Mental Health Systems
- Schools

Develop an action plan to support inter-agency collaboration, communication, and education for industry stakeholders, such as plans and facilities, consumers and legislators, including, but not limited to:

- Providing services for children with autism – spectrum disorders.
- Clarifying definitions of severely emotionally disturbed children, including specific Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the International Classification of Diseases (ICD-9) diagnostic codes linked with specific functional impairments
- Addressing program fragmentations between and among the private, state and public programs
- Engaging data resources, such as the Office of Statewide Health Planning and Development, to understand and provide suggestions to address the shortage of mental health professionals in the work force
- Identifying barriers to consistent administration of services and benefits for children diagnosed with autism, and addressing this issue on the plan level between the full service and the mental health service providers, and also on the system level, in collaboration with the regional centers of the Department of Developmental Services

RECOMMENDATION 2 **CONTINUE STAKEHOLDER FORUMS**

Convene stakeholder forums with professional associations of psychiatrists, mental health clinics and hospitals, psychologists, social workers, marriage and family therapists, employers, and plans to identify and evaluate issues specific to the provider community.

Proposed Actions

Develop an agenda of issues specific to the professionals who provide mental health services, including:

- Mental health admission processes and coordination between plan and facilities, i.e., emergencies, benefit verification, prior authorization, coordination between medical and mental health benefits
- Coordination and network issues for post-discharge and follow-up appointments, such as the plan requirement for a "panel provider" to approve patient admission and follow-up care
- Problems encountered with the plans' out-of-state call centers
- Coordination issues between facility providers and the plans about requirements to use plan-specific formularies, use of plans' access numbers for enrollee ID cards, and requirements to coordinate facility-to-plan physician reviews
- Standards or guidelines for responding to after-hours and emergency communications from patients, and linking information to the DMHC regulatory process

Incorporate feedback information into legislative workgroups and the regulatory process, as needed.

Monitor plans for consistency with existing clinical standards regarding continuity and completion of covered services.

RECOMMENDATION 3 **ASSESS AND CLARIFY REGULATIONS FOR AFTER-HOURS SERVICES AND DENIALS**

Clarify regulations, if needed, for after-hours and emergency responses to calls from or about mental health patients.

Proposed Actions

Actively participate in the development of access regulations, ensuring that mental health stakeholder concerns are addressed.

RECOMMENDATION 4	ENHANCE CONSUMER INFORMATION ON THE DMHC WEBSITE

Revise the DMHC public website to include information and relevant materials about statutes, regulations, and survey results, as well as an overview of the scope and progress of the DMHC's efforts in the area of mental health.

Proposed Actions

Post DMHC points of contact, document updates, action plans and dates of completion. Include a mechanism for consumer feedback.

Ensure that information meets consumer readability and understandability requirements.

Work in collaboration with OPA to expand sources and mechanisms for distributing consumer information about mental health care. (See Recommendation 6.)

RECOMMENDATION 5	CONTINUE OVERSIGHT OF MENTAL HEALTH RELATED GRIEVANCE AND INDEPENDENT MEDICAL REVIEW (IMR)

Continue oversight of plan handling of consumer and provider issues prior to submission to the DMHC through the complaint and/ or IMR application process.

Proposed Actions

The HMO Help Center will continue analysis of plan compliance with the Knox-Keene Act and particularly the handling of mental health service complaints and grievances. Discuss ways to encourage IMR submission on mental health issues.

RECOMMENDATION 6 **COORDINATE A CONSUMER EDUCATION PROGRAM**

The HMO Help Center, in conjunction with the Office of Patient Advocate, will disseminate materials concerning mental health parity and consumer rights to community advocacy groups, psychiatric facilities, and provider associations.

- Develop information for consumers and providers that includes the definition of "severely emotionally disturbed" and examples of conditions considered in this category.
- Develop information that describes procedures for seeking a diagnostic assessment for autism.

Proposed Actions

Establish a DMHC/Office of the Patient Advocate Joint Work Group to collaborate and educate consumers about the delivery system for mental health care in California.

Inform enrollees about choices in the mental health system and benefit coverage offered by the plans, various state agencies, and the community.

Inform enrollees and families about mental health services in the community, and distinctions in coverage between public and private coverage.

RECOMMENDATION 7 **RESEARCH AND REPORT PLAN REIMBURSEMENTS TO PUBLIC AGENCIES**

Identify government sources of health care services for children and adolescents. Determine the legal implications and practicability of allowing health plans to contract with or reimburse public agencies/ government programs for services otherwise required under the Knox Keene Act.

Proposed Actions

Appoint an internal Legal Counsel Work Group to perform an analysis.

Link information and discussions to the Inter-Agency Collaborative Work Group on Mental Health.

RECOMMENDATION 8	**ESTABLISH A WORK GROUP WITH REPRESENTATION FROM CAHP, HEALTH PLANS, PROVIDERS, CONSUMERS, EMERGENCY SERVICES, AND DMHC REGULATORS TO DISCUSS ALTERNATIVES AND IMPROVEMENTS IN MENTAL HEALTH DELIVERY SYSTEMS**

DMHC will work proactively with health plans to address common and continuing mental health delivery system complaints, such as ease of entry to the delivery system, phone systems, appointment wait times, access to services, and the grievance process.

Link information to DMHC regulatory and survey processes as necessary.

Proposed Actions

Explore with CAHP and health plans the opportunity for changes to the appeal process involving mental health parity diagnoses, such as a fast track procedure whereby the appeal would go automatically to the DMHC.

Consider alternatives to the current automated Interactive Voice Response (IVR) phone systems, such providing an “opt out” feature that allows callers to either contact a live plan representative who has expertise in dealing with mental health issues, or limit the number of IVR options available so that the caller is able to reach information quickly.

Work on solutions for facilitating easy access to mental health providers, such as requiring mental health carve-out plans to place their phone numbers conspicuously on the members’ ID cards.

Identify alternative access choices for enrollees who are in mental health crisis. Consider alternatives such as providing a direct link to the advice nurse, or expanding access to services through case management programs.

Consider making standing authorizations for specific benefits, or make process changes to ease the authorization process. Monitor the timeliness of the utilization management (UM) decisions specific to mental health service requests. Ensure that the personnel involved in UM have the proper licensure and expertise.

Recommendations to the Health Plans

RECOMMENDATION 9	EMERGENCY ROOM CLAIMS PAYMENT POLICY

Eliminate payment delays through compliance with existing regulations.

Proposed Actions

Avoid placing enrollees in the middle of payment disputes between full service plans and their carve outs.

Closely evaluate current claims payment policies, and audit compliance with requirements for swift medical review of claims.

Consider automatic payment of ER claims, and audit claims retrospectively for adherence to policies.

Explore claims process improvement opportunities involving involuntary admission (5150s) in order to prevent hospital claims from being denied, which puts the payment responsibility on the enrollee.

RECOMMENDATION 10	INVESTIGATE CONSUMER CONCERNS ABOUT PHANTOM NETWORKS

Perform regular checks of appointment availability, confirm that “open” practices are accepting new patients, and closely monitor the number of times that enrollees who are unable to obtain appointments call back to get the name of an another provider, and monitor enrollee complaints.

Proposed Actions

Improve internal health plan processes to ensure that information about provider availability is accurate before providing the provider list to consumers who are seeking a mental health provider.

Revise customer service policies to require staff to assist consumers to find a behavioral health provider. Plan representatives should work with the enrollee to secure a provider or appointment if the enrollee has made three unsuccessful attempts to obtain an appointment.

Utilize the health plans’ quality improvement programs to track and monitor provider network complaints and calls that relate to the inability to find a mental health provider who will accept new patients.

RECOMMENDATION 11 ACCOUNTABLE COORDINATION OF CARE

Facilitate coordination of care, holding providers and case managers accountable for communicating and coordinating with other providers and entities. Assess and improve communication between physicians and behavioral health providers through file audits and tools. Develop written protocols to guide interaction between medical and mental health care management staff.

Proposed Actions

Make case managers aware of information about services available in the enrollee's local service area, such as services specific to autism.

Require case managers to coordinate services outside of the plan as needed, such as with school systems or state-run programs.

Consider expanding case management programs to include the following:

1) Provide liaison and assistance for enrollees in emergency or crisis situations by providing case management access numbers, voice-mail, and after hours access if needed.

2) Provide information and assistance to enrollees who are eligible for local and regionally based mental health services. Provide reference sources to case managers to ensure that they are knowledgeable about California's mental health system and how best to advise an enrollee in accessing services that may not be available from the health plan, but could be available through an alternative program.

3) Coordinate medical and mental illness case management programs.

4) Facilitate communication and coordination among programs staffed by carve-out plans, medical groups and the plan-based programs.

RECOMMENDATION 12 COORDINATION OF SERVICES AND COMMUNICATIONS BETWEEN THE HEALTH PLAN AND MENTAL HEALTH "CARVE OUT" ARRANGEMENTS

Health plans that carve out mental health services to specialty mental health plans should re-examine communication systems and any barriers to coordination of care in such arrangements.

RECOMMENDATION 13 PLAN REIMBURSEMENTS TO PUBLIC AGENCIES

Explore opportunities to contract or develop memorandums of understanding with Regional Centers to address problems with payment issues for services provided to health plan enrollees through Regional Centers.

A P P E N D I X A

SURVEY METHODOLOGY

The DMHC selected seven of the largest health plans in California (based on enrollment size) for this study.

Collectively, these plans cover all geographic areas of the state and provide coverage for 85% (approximately 16 million) of California's commercial managed care population.

The DMHC designed and developed a tailored survey tool that specifically assesses plan compliance with the provisions of the Parity Act, and conducted focused surveys of the seven large health plans selected for this study. The DMHC advocated a focused survey approach to allow for a detailed look at the application of and compliance with the requirements of section 1374.72 of the Knox-Keene Act. This approach also allowed the survey team to concentrate its efforts on assessing potentially serious health plan problems and concerns raised by the consumer and industry stakeholders about the implementation of the Parity Act and quality of mental health services.

Development of a Standardized Survey Tool

Legal counsel and mental health and survey experts assisted in developing the audit tool. Experts including psychiatrists, clinical psychologists, a pediatrician, a licensed clinical social worker (LCSW), a psychiatric nurse, claim auditors, and public health professionals worked together to:

- ☑ Review the provisions of section 1374.72 of the Parity Act and Rule 1300.74.72 to define specific performance standards against which plans will be measured.
- ☑ Define details of the assessment methodology.
- ☑ Perform document review (e.g., case file review, claims review, examination of policies and procedures) to determine:
  - Specific documents and materials to be requested
  - Sample sizes and sampling procedures
  - Specifications for claims summaries and individual claims listings
- ☑ Determine which activities/responsibilities should be assessed at full-service plans and which should be assessed at associated mental health specialty plans to which services are "carved out" (if applicable).
- ☑ Develop a survey protocol, *Parity Technical Assistance Guide* (Parity TAG), to standardize the survey assessment process by listing performance standards, assessment tasks, materials, processes, and documents to be examined and individuals to be interviewed.

- ☑ Create a computerized Findings Tool based upon the Parity TAG that allows surveyors to record their findings for each standard.

The subjects covered in the Parity TAG determined whether the plan and its contracted mental health plan were:

- ☑ **Ensuring Access and Availability of Services** – whether the plan developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services
- ☑ **Administering Benefits and Managing Utilization of Services** – whether the plan appropriately authorized and provided medically necessary treatment and services mandated under section 1374.72 under the same terms and conditions applied to medical conditions
- ☑ **Ensuring Continuity and Coordination of Care Among Providers** – whether the plan is effectively coordinating the care of enrollees and providing continuity of care
- ☑ **Managing the Activities of Specialty Mental Health Plans to Which Responsibilities Are Delegated** – when applicable, whether the plan adequately and appropriately oversees the contracted specialty mental health plan to ensure that it complies with all applicable standards

Selection of Health Plans

For this project, the DMHC selected seven of the largest health plans in California, based on enrollment size. Collectively, these plans cover all geographic areas of the state and provide coverage for 85 percent (approximately 16 million consumers) of California's commercial managed care population. They also represent the full range of delivery models that plans use to provide mental health services. Models include the integrated, the subsidiary, the carved out, and the single plan (see Appendix B).[13]

[13] Note that a number of employer groups elect to "carve out" mental health services to MBHOs. A full-service plan is separately selected to administer physical health benefits. In this situation, the full-service plan and the MBHO do not have any contractual relationship or obligation to one another and linkage may not be present. This segment of mental health consumers is not represented in this study.

Survey Process

Prior to the onsite focused survey, the DMHC required the seven plans to respond to the Pre-Onsite Visit Questionnaire and submit documents giving an overview of plan operations, policies, and procedures. During the visit, the DMHC asked the plans to provide additional materials, such as utilization review files (e.g., service denials), claim files, and various internal management and performance reports for review.

The on-site focused survey was conducted at the plans' corporate offices. For carved-out and subsidiary models, the survey was conducted at the corporate offices of the associated specialty mental health plans; however, key officers and staff from the full-service plans were on hand to assist and respond to questions regarding operations and delegation oversight.

In its review of enrollee files, the survey team focused on measures such as:

1) Appropriateness of any pre-service denials and claim denials based on plan determinations that the services were not medically necessary or were not covered benefits
2) Timeliness of decision-making
3) Evidence of appropriate and timely coordination of care and appropriate exchange of information among providers

The survey team also conducted a random telephone survey of each plan's mental health providers to assess appointment availability and evaluate how well the providers' after-hours telephone messages instructed callers how to access emergency services.

To augment document review and obtain a comprehensive picture of health plan activities and challenges surrounding the implementation of section 1374.72, the survey team interviewed officers and staff from both the full-service plans and associated specialty mental health plans, as applicable.

Focused Survey Reports

Following the on-site visit, the DMHC issued to each of the seven full-service plans a preliminary report that detailed the survey findings and described the required corrective actions for any identified deficiencies.

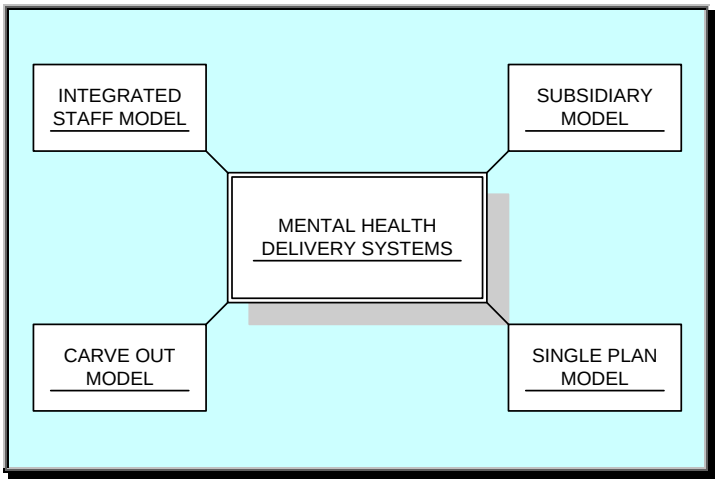
Each plan was given 45 calendar days from the date of receipt of the preliminary report to respond in writing and submit evidence that the required corrective actions had been implemented or were in process of being implemented. Upon review of a plan's response to the preliminary report, the DMHC issued a final report containing the survey findings as they were reported in the preliminary report, a summary of the plan's response, and the DMHC's final compliance determination.

A P P E N D I X B

OVERVIEW OF MENTAL HEALTH DELIVERY SYSTEMS

Full-service plans deliver mental health services through the following models:

Integrated Staff Model – The full-service plan utilizes a group of employed mental health providers co-located or closely linked with the medical providers within the delivery setting. Both the medical and mental health providers belong to a multi-specialty group either employed by or contracted with the health plan. An example of this model is Kaiser Foundation Health Plan, Inc. (There are a small number of exceptions to this co-location in areas such as Stanislaus County, where Kaiser operates a combination of staff and network model services.)



Carve-Out Model – The full-service plan contracts with an MBHO, a specialty plan. The full-service plan may retain certain financial risks for select services, such as out-of-network and out-of-area mental health services. It may delegate the processing and payment of service claims for which the MBHO is at financial risk. An example of this model is San Francisco-based Blue Shield of California, which contracts with U.S. Behavioral Health, an MBHO headquartered in San Diego, California.

Subsidiary Model – The full-service plan contracts with a subsidiary that specializes in mental health services. A subsidiary need not be exclusive to the full-service plan. It may be an MBHO that contracts with other health plans or with employer groups. The subsidiary recruits and maintains its own network of mental health providers. Similar to the Carve-Out Model, the full-service plan delegates managed care functions, such as network management, credentialing, utilization management, case management and quality management. Claims processing and payment may or may not be a delegated responsibility. Some subsidiaries do not have their own claims departments, in which

case the associated full-service plan retains the responsibility for processing claims. An example of a subsidiary model is PacifiCare of California in Cypress, California, which contracts with its subsidiary, PacifiCare Behavioral Plan, located in Sherman Oaks, California.

Single Plan Model – The full-service plan contracts directly with mental health providers and creates its own mental health provider network. The plan's own behavioral health division, staffed by mental health professionals, administers the benefits and the delivery of mental health services. Notably, while it is part of the full-service plan, the behavioral health division appears to operate much as a separate entity or a subsidiary with its own utilization and quality management departments. However, one common claims department pays claims. An example of this model is Blue Cross of California, headquartered in Woodland Hills, California, whose behavioral health division is located in San Diego, California.

A P P E N D I X C

HOW PLANS DEVELOP AND MAINTAIN NETWORKS

The Parity Act requires the plan to provide at a minimum, "crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists." To achieve this, the plan contracts with qualified individual mental health practitioners (evidenced through education and experience), multi-specialty mental health provider groups, licensed institutions/facilities (such as inpatient hospitals), and special treatment programs (such as eating disorder programs), to create a network of mental health providers whose services are accessible and available.

The survey team noted low numbers of available and qualified mental health clinicians (e.g., adult and child psychiatrists, child psychologists) in several rapidly growing areas such as Stockton and Modesto, and in some rural areas.

There must be a sufficient number of providers, proportionate to the number of enrollees and appropriately distributed geographically, to ensure timely access for all enrollees. The survey team assessed plan data regarding their respective networks and interviewed plan staff members to identify concerns about their established networks. The survey team identified the shortage of four provider types as presenting the greatest challenges to California plans as they work to maintain and enhance their mental health provider networks:

- ☑ **Psychiatrists –** Psychiatrists are physicians who are trained to evaluate and treat individuals with mental health disorders. Psychiatrists and Ph.D. level clinical psychologists are the only mental health providers who can admit patients to the hospital for treatment. Plans consistently identified a shortage of psychiatrists—especially in rural areas—as presenting a challenge to creating an adequate network and providing timely access to appointments. Plans, consumers, and state agencies have recognized this ongoing concern as a significant issue.

- ☑ **Pediatric and Adolescent Mental Health Practitioners** – Six of the seven plans identified a statewide shortage of child psychiatrists to provide evaluation and treatment of childhood disorders as a problem. Child/adolescent psychologists, as well as other therapists specializing in children and adolescents, were also in short supply in some geographic areas.

- ☑ **Residential Treatment Centers (RTCs) –** These centers typically are used for eating disorders and adolescent behavioral disorders—the latter often with attendant substance abuse co-morbidity. The coverage and use of RTCs vary markedly among plans, ranging from almost no coverage to coverage equivalent to that for skilled nursing facilities. Stakeholders and plans expressed concern about the scarcity of RTCs, inadequate access to structured programs and intensive services, and long waiting lists for admission.

- ☑ **Eating Disorder Programs –** All seven plans surveyed provide treatment for eating disorders (anorexia and bulimia) in varied settings, including inpatient programs, intensive outpatient programs, partial hospitalization programs, and residential eating disorder treatment programs. Plans consistently pointed to the common concern of a shortage of well-structured residential eating disorder programs, especially for children/adolescents.

The survey team noted low numbers of available and qualified mental health clinicians (e.g., adult and child psychiatrists, and child psychologists) in all specialties in several rapidly growing areas such as Stockton and Modesto, and in remote rural areas.

One integrated plan stated that inpatient beds in Northern California have decreased by 400 since 1999. Specific geographic areas lack specialty providers and certain facilities. A shortage was also noted for other programs, such as inpatient facilities for children, locked long-term care facilities for all age groups, and bilingual providers.

A P P E N D I X D

ACCESS TO MENTAL HEALTH SERVICES

How Consumers Obtain Services

Plan systems for evaluating and controlling the use of mental health services vary in design. The most common "ports of entry" for accessing mental health services are:

Primary Care Provider Referral

While PCP referral is generally not required, this is the most common point of entry to the mental health delivery system. Often these medical providers are the first to recognize the need for mental health services.

Open Access – An enrollee may self-refer to any mental health provider in or out of the plan's network without preauthorization, but only for outpatient mental health services, such as outpatient therapy sessions and medication visits. Use of nonparticipating providers is associated with higher co-payments. Typically, an enrollee calls a mental health service toll-free 24-hour telephone number listed on the back of the enrollee identification card to inquire about benefits, or, if necessary, to request referral to a mental health provider. Only one of the seven plans offers open access.

Limited Direct Access (or Semi-open Access) –The plan approves the first six to 12 outpatient visits without preauthorization. Once treatment is established and additional visits are necessary, the plan requires the enrollees or their providers to contact the plan and obtain preauthorization for succeeding visits. Five of the seven plans surveyed allow enrollees to self-refer directly to a provider for routine appointments without preauthorization from the plan or referral from the PCP.

Primary Care Provider Referral – While a PCP referral is generally not required, it is the most common point of entry to the mental health delivery system. Often medical providers are the first to recognize the need for mental health services. For those plans that allow direct access or self referral, the PCP either refers the enrollee to an associated mental health provider group that also contracts with the plan, or instructs the enrollee to call the toll-free telephone number for mental health services for assistance in identifying a mental health provider in the enrollee's service area.

Plan-operated Screening, Triage, and Referral – All seven plans provide a toll-free 24-hour telephone number for mental health services that enrollees can call to initiate a service referral. For

plans that offer the open access option, enrollee use of the service line is optional; however, enrollees may use it to obtain guidance on benefits, to identify the type of provider appropriate to their needs, or to obtain information on providers in their geographic areas.

Plans that restrict direct access require enrollees to call the service line for preauthorization, as well as for guidance and referral information. Alternatively, when referral arrangements are secured through the 24-hour service lines, many plans provide assistance to the enrollee by making special arrangements and appointments on the enrollee's behalf. The plan intervenes when the enrollee has not been able to make an appointment with a provider from the list initially provided by the plan, or facilitates an initial appointment when it appears that the enrollee is in crisis.

The following provisions describe how enrollees may obtain various types of mental health services from the seven plans surveyed:

Urgent/Emergency Care – All plans invoke the prudent layperson rule to determine whether an enrollee's decision to seek emergency care will be covered. No plan requires preauthorization for emergency services. The 24-hour service lines provide triage and screening services by qualified mental health professionals to direct enrollees to the appropriate providers.

Outpatient Service – As mentioned above, plans vary in their intake and referral mechanisms. Only one plan allows open access for outpatient routine appointments. Another plan requires enrollees to call the mental health service's toll-free service line to initiate a referral. Five plans offer limited direct access for routine outpatient visits. These plans will typically authorize a limited number of sessions and then, if additional sessions are desired, require an evaluation of the provider's treatment plan to determine the necessity for continued visits. Generally, additional authorized visits are allowed for medication visits with a psychiatrist.

Other ambulatory services, such as biofeedback, outpatient electroconvulsive therapy, hypnosis, and psychological testing, require preauthorization or referral (all plans). Intensive outpatient programs also require preauthorization.

Inpatient Service – Plans and their associated mental health specialty plans typically require preauthorization for all inpatient services and any inpatient levels of treatment that use medical necessity criteria and evidence-based practice guidelines. Inpatient

services include acute hospitalization, partial hospitalization, and residential treatment programs. Other special intensive programs, such as eating disorder treatment programs, fall under inpatient services, and therefore require preauthorization.

How Quickly Can Consumers Obtain Services?

Contingent upon DMHC approval, plans must set internal performance standards for access to and availability of mental health services. When plans fall below these standards, the DMHC requires that they initiate corrective actions to improve performance. The table below displays the key access and availability standards established by the seven plans. (Some plans establish their standards with a corresponding performance goal, e.g., 95 percent of routine appointments within 14 days.)

Table 2

ACCESS & AVAILABILITY STANDARDS

Type of Service	Aetna	Blue Cross	Blue Shield	Cigna	Health Net	Kaiser	PacifiCare
Non-life-threatening Emergency	95% percent of appointments within 6 hours	Within 6 hours	100% within 6 hours	Within 6 hours	Within 6 hours	Immediate	6 hours
Urgent Care	95% of appointments within 48 hours	Within 48 hours	100% within 48 hours	Within 48 Hours	48 hours	1 day for Urgent/ Initial Visit	48 hours
Initial Post-hospitalization Follow-up Visit	Appointment within 7 calendar days of discharge	Within 7 days	Within 7 days of discharge	Within 7 Days	7 calendar days	7 calendar days from discharge	7 days
Routine Visit	85% of appointments within 10 days	Within 10 working days	100% offered within 10 business days (90% kept)	Within 10 Days	10 business days	2 weeks	10 business days

Plans must also educate enrollees about available services, and how and where they can access these services. Because the Parity Act eliminated benefit limitations on coverage for mental health services, it is especially important that plans accurately communicate the expanded benefits available to individuals with parity diagnoses. Plans use various methods to tell enrollees about accessing services and to describe covered benefits under the plan.

Some of these examples include:

- ☑ Evidence of Coverage document (distributed to each enrollee at the time of enrollment to provide a formal statement of covered benefits and exclusions, operational policies and requirements, and plan/enrollee responsibilities)
- ☑ Identification cards
- ☑ Customer service/intake lines
- ☑ Member newsletters
- ☑ Educational materials
- ☑ Telephone screening for serious mental illness
- ☑ Enrollee web sites
- ☑ Provider directories

A P P E N D I X E

ISSUES IMPACTING MENTAL HEALTH PARITY (THE DETAIL)

The following section provides a detailed explanation of the issues identified during the surveys, which were summarized in Section III, Table 1 of this report.

1) Parity-Specific Issues Stemming From AB 88 Legislation

A number of issues arose from a need to further clarify:

- Requirements of the parity legislation, and
- Appropriate assignment of responsibilities for provision of services under the legislation.

a. Coverage of Only a Partial List of Mental Health Diagnoses Results in Definitional and Diagnostic Challenges.

AB 88 provides for parity coverage only for certain mental health conditions, including SMI in adults and SED in children. This has made understanding and administering requirements and benefits difficult.

Because AB 88 covers only certain conditions, distinguishing between parity and non-parity diagnoses presents problems in providing a seamless administration of benefits. Plans shared the following insights:

- Providers find the definition of SED for children challenging. To qualify for parity-level coverage, children must meet one or more of the following functional criteria: substantial functional impairments; risk of removal from the home; a mental disorder or impairment present for more than six months; psychosis, risk of suicide or violence due to a mental disorder; or eligibility for special education.

- Children must be diagnosed with a mental health condition listed in the DSM-IV. The inclusion of functional criteria as a part of the definition is a challenge for plans both in identifying parity diagnoses (which may require sharing information with schools, social workers, legal entities, and other agencies) and in computerized tracking and billing for

these diagnoses, as previous classifications relied on diagnostic codes.

Several plans reported difficulty in distinguishing between parity and non-parity cases, and this contributed to the decision to treat all mental health diagnoses for children as parity diagnoses for purposes of benefit/payment determinations.

- The use of Welfare and Institutions (W&I) Code section 5600.3 to define SED caused some confusion with practitioners historically more familiar with the special education eligibility requirements for SED under chapter 26.5 (commencing with section 7570) of division 7 of title 1 of the Government Code. The W&I Code provided a broader, more flexible definition. One plan reported that it had to thoroughly educate providers in an effort to help them correctly identify children eligible under this broader definition.

- The law clearly defines diagnoses for adults, but not for children and adolescents. The law also defines diagnoses by DSM-IV codes only, while some plans rely on ICD-9 codes to pay claims. The lack of such definitions has led to the challenge of interpreting whether certain diagnoses are to be included under parity.

As a result, plans have encountered difficulty in clearly defining coverage, and in educating enrollees as to the nature of parity diagnoses.

b. There is a Lack of Clarity Regarding Responsibility for the Diagnosis and Treatment of Autism-Related Disorders.

Although five of the seven plans surveyed have established procedures for collaborating with regional centers, much uncertainty remains about the limits of responsibility. Specific areas of uncertainty include the following:

- The relative responsibilities of health plans and regional centers for children under age three for whom federal laws governing early intervention services (Part C of IDEA) make utilization of the health benefit plan voluntary on the part of parents

- The role and responsibility of the public school system in providing ancillary services, including SLT and OT for children age three and older, as part of an individualized education program (IEP)

- The responsibility of health plans to provide services to these children, other than medication management and individual and family therapy

Beyond the uncertainty regarding responsibilities, several related issues have significance:

- Most of the plans surveyed require parents to go through the specialty mental health plan to obtain referrals for autism evaluation, medication management, and therapy; however, they must go through their primary care physicians to obtain referrals for SLT and OT. Because five of the seven surveyed plans have a capitated contract with a primary medical group (PMG) that includes SLT and OT as a medical service rather than behavioral health capitation, the PMG is responsible for authorizing and paying for these services.

- Inconsistent coverage occurs for ABA, a very costly service. Some clinicians consider ABA a critical service provided almost universally to young children with autism-related diagnoses. None of the plans, however, cover ABA services per se, citing one or both of the following reasons:

  a) Empirical evidence is currently insufficient to indicate that ABA is an effective treatment for autism, and
  b) ABA services are typically provided by unlicensed individuals under the supervision of licensed mental health professionals. At least one plan reported covering ABA only when it is provided as part of a time-limited, structured intensive outpatient program.

- All stakeholder groups must wrestle with a lack of empirical evidence about the causes of autism and the effectiveness of various treatment options. One plan reported that labeling of some treatments as experimental, such as sensory integration therapy, has created tension between families and health plans.

- Plan personnel also emphasized the negative impact of funding reductions in both the school system and regional centers on the availability of services for these children. Long waiting lists prompt parents to go back to the plans for coverage of these services. Children/families can easily get passed back and forth between the public and the private systems, both of which attempt to provide high levels of needed services with limited funding.

- In several plans, one or more case managers gained expertise on autism and personal familiarity with the programs and care providers available; however, the lack of formalized processes, care protocols, and agreements with regional centers make this a fragile situation should staff turnover occur.

c. Exclusion of Parity-Level Coverage for Substance Abuse Impedes Treatment of Enrollees with a Dual Diagnosis of Mental Illness and Substance Abuse.

At the individual case level, untreated substance abuse can mask, as well as exacerbate, the symptoms of mental illness. Patients are often reluctant to enter substance abuse treatment due to denial and other reasons. Variation in coverage, or no coverage, for substance abuse further reduces the likelihood of proper treatment. As a result, successful treatment of the co-occurring mental disorder is compromised by ongoing substance abuse.

At the system level, resources (facilities or providers) tend to treat those conditions for which funding is most readily available. In a finite pool of dollars made available to treat mental health/chemical dependency disorders by health plans, if a disproportionate percentage goes to treating the parity mental disorders, care for other conditions may be at risk. Substance abuse disorders are also more likely to be (mis-) diagnosed as mental illness in order to favor chances for funding.

One plan observed that AB 88 did not clearly delineate the expectations for all stakeholders, especially counties and the state, which are limited by budgetary and staff constraints, to fulfill its missions. The plan noted that even though chemical dependency (CD) treatment is not included in parity, it has been providing more CD treatment, particularly to individuals who have both mental health and CD problems.

The limited availability of appropriate support services, such as housing, prevents adequate maintenance of individuals who have mental health illnesses and/or CD problems in the community. Wrap-around services and support services were neither funded nor evaluated.

2) The Challenges of Coordinating Care Among a Myriad of Payors, Providers, and Agencies

Even when responsibilities under parity are clearly defined and understood, they are shared among several entities (e.g., full-service plans, specialty mental health plans, schools, regional centers, county mental health plans). Furthermore, plans divide responsibilities among a variety of health care service providers. This division of responsibility, while certainly appropriate due to the varying roles and expertise of each participant, presents challenges in coordinating care to ensure that services are delivered efficiently, effectively, and with minimal confusion and frustration for providers and enrollees.

a. The Plans Vary Significantly in Programs and Strategies Designed to:

- ☑ **Ensure continuity and coordination of care between the medical and mental health sectors.**
- ☑ **Identify and ensure appropriate treatment/referral for mental health conditions in the primary care settings.**

Plans cited HIPAA and enrollees' desire to keep their mental health conditions and treatment confidential as the major reasons for reluctance on the part of mental health providers to share information.

Rule 1300.74.72 of the California Code of Regulations requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and to ensure continuity and coordination of care for enrollees (e.g., monitor collaboration between medical and mental health providers, facilitate access to treatment, and follow-up for enrollees with co-existing medical and mental health disorders). All plans have written policies intended to ensure appropriate handling of these aspects of their services, including requirements for communication between practitioners and contracting plans and (medical) disease management programs that address mental/behavioral co-morbidities. However, the effectiveness of these policies varies greatly among plans and appears to be strongest in plans where mental health providers are "co-located" within the primary and specialty medical settings.

A potential obstacle to communication among providers is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the fear of, and perhaps misinterpretation of, its confidentiality requirements. Plans cited HIPAA and enrollees' desire to keep their mental health conditions and treatment confidential as the major reasons for reluctance on the part of mental health providers to share information. Certainly obtaining signed consent, whether required or not, can be quite challenging. This is especially true when underage patients must have parents sign for them. Obtaining the proper consents in order for multiple agencies, providers, and health plan personnel to share information can be extremely time consuming.

The carve-out environment appears to be at variance with the need for effective integration of medical and psychiatric services for biologically based illnesses. Often, PCPs instruct enrollees to contact a toll-free number for mental health referrals. Timely communication and sharing of information may be inconsistent, if not absent, because the PCP and the providers from the specialty plan do not generally belong to the same provider group.

b. The Nature and Levels of Case Management Services Vary Markedly Across Health Plans

Case managers assist in coordinating and arranging for care and benefits for complicated cases that require the services of multiple health care service providers. Some plans offer extensive case management programs with specialized programs for individuals with autism and eating disorders. One plan, for example, has developed a sophisticated system of case/care management for behavioral health services in which the care manager plays a multiform role, including direct service provider, referring source, formal liaison with the medical care system and advocate for the patient and his/her family.

Another plan based on the open access model merely employs traditional utilization review geared toward reviewing services for medical necessity, with no focused case coordination/management. Others have some form of case management ranging from full coordination and follow-up to periodic communication with enrollees.

The lack of clearly defined regulatory and industry expectations also contribute greatly to this variation. Given the

complexity of parity conditions and the need to coordinate several aspects of their care (physical/mental/psycho-social), effective collaborative case management is essential.

c. The Division of Financial Responsibility Arrangement Between Full Service and Specialty Plans Complicates Case Coordination and Management

The division of financial responsibility between the contracting entities may impede case coordination. The following scenario is illustrative:

A plan enrollee who suspects autism in her three-year-old child encounters several entities from the very outset: the full-service plan, the specialty mental health plan, the primary care medical group and the regional center. Although the medical group's pediatrician suspects a diagnosis of autism, the medical group, is not responsible (professionally or financially) for evaluative services for autism, which is considered a mental health parity diagnosis. The pediatrician, therefore, instructs the enrollee to call a toll free number (that of the specialty plan) for mental health services to request a referral to a provider with expertise in evaluating children for autism. The specialty plan staff assists the enrollee by undertaking one or more of the following actions depending on the policy of the plan and the customer service representative's willingness/ability to help.

1. Providing a list of providers that the enrollee can call
2. Performing an initial needs assessment through a series of questions, along with concurrent referral to a case manager
3. Offering the option of seeing a network provider, or going to the regional center for evaluative and treatment services
4. Directing the enrollee to the regional centers
5. Facilitating and coordinating a referral to a specialist

If the enrollee obtains a diagnosis of autism from a specialty provider, the child is then prescribed a number of treatment modalities including, but not limited to, SLT, OT, and ABA. The enrollee contacts the specialty plan again for the provision of these services. The specialty plan staff refers the enrollee back to the medical group for authorization of OT and SLT therapy (because the medical group is financially responsible for these services under its capitation agreement with the full-service plan). At the same time, the specialty plan encourages

the enrollee to go to the regional center for the ABA therapy because the plan does not cover/pay for such therapy, which is deemed neither medically necessary or experimental. The medical group then refers the enrollee to an occupational and speech therapist within its local network. The medical group may or may not have case managers following the case. The result is fragmented coordination and communication between these entities and the providers.

An enrollee is likely to find the process somewhat less cumbersome within those health plans that arrange for appointments on the enrollee's behalf, or assign the enrollee to a case manager with expertise in managing children with autism, and who will assist the family in navigating the health delivery system.

Some parents educate themselves about the role of and services available from the regional centers, but others are unfamiliar with the role these centers play. Since most health plans do not generally hand-hold parents, case management varies from very tight, to very loose, to none at all.

Parents also encounter the educational system, which provides SLT and OT at no charge for school-age children. However, the school's ability to provide these services depends on the availability of funds and adequacy of staffing.

d. Significant Variation Occurred in the Plans' Observed Capacity to Ensure Accurate and Timely Payment of Emergency Room Claims

Problems with prompt and accurate payment of emergency room claims, from both participating and nonparticipating practitioners and facilities, is a consistent finding. The problem is exacerbated when plans carve out mental health services to a separate capitated entity. Determining who is financially responsible for which services when an enrollee appears at an ER with both medical and behavioral health problems is particularly problematic. The decision process often results in delayed payment of ER claims, and, sometimes, incorrect payment denials.

3) The Health Care System - Systemic Gaps And Deficiencies

Services required under the Parity Act are provided within the larger setting of the health care system. Gaps and deficiencies in this system, while not specific to parity, will impact the provision of parity services.

a. Significant Variation in Coverage, Availability and Quality of Services Offered by Residential Treatment Centers, Resulting in Inconsistent Services across Plans

RTCs are typically used for eating disorders and adolescent behavioral disorders—the latter often with attendant substance abuse co-morbidity. The coverage and use of RTCs varies markedly among plans, ranging from almost no use to coverage of facilities on par with skilled nursing facilities. Several factors contribute to this variation in coverage and use of RTCs:

- Plans expressed concerns about the utility of RTC treatment because significant variation has historically existed in program purpose, structure, demonstrated efficacy, and overall quality.
- No recognized or generally accepted national accreditation body for residential treatment programs helps to ensure consistency in structure, operations, and quality of care at RTCs. One plan reported that, as a result, it conducts its own thorough credentialing review to evaluate the quality of these programs.
- Plans that cover residential treatment generally distinguish between the cost of behavioral health therapeutic activities and the cost of the educational program (tuition) because the latter is not a medically necessary service for which the plan would be responsible.
- Plans that cover residential treatment may deny RTC coverage for either of two reasons: 1) the RTC does not meet intensity-of-service criteria (the program does not provide the structure and level of service generally required in dealing with certain disorders/diagnoses); and 2) the RTC is not a network participant for reasons such as lack of credentials and lack of a structured program.
- Generally, plans offer a choice of benefit packages both with and without RTC benefits; therefore, RTC coverage is dependent upon the benefit plan package that employers purchase for their employees.

Plans reported using varying approaches to RTC coverage:

- Four plans offer RTC coverage as an optional benefit. When RTC is a covered benefit, one plan applies no benefit limit, whereas the other three apply the limit (e.g., 30 days per calendar year) stated in the benefit contract. One plan offers the option to flex benefits on a case-by-case basis for enrollees who do not have an RTC benefit. Another plan allows conversion of other mental health benefits to RTC benefits. For example, one in-patient day can be converted to two RTC days.
- One integrated plan does not routinely offer RTC coverage, nor does it routinely use RTCs. It is not a covered benefit for most enrollees. This plan perceives that RTCs are generally ineffective in dealing with underlying issues, and ineffective in providing discharge planning, resulting in a return to previous behaviors upon return to the community.
- One plan has made a policy decision that, under parity, RTC services are covered for all age groups and are comparable to skilled nursing home facility services, with the same benefit limit (100 days per calendar year) and co-payments.

All seven plans expressed concern about the scarcity of available RTCs offering a comprehensive program and a demonstrated level of effective, high quality care, especially for children and younger adolescents. Consensus among mental health professionals indicates the necessity of relatively prolonged residential treatment for such specific conditions as severe eating disorders and some dual diagnosis (combined mental health and substance abuse) disorders. The lack of access to RTCs for the members of some plans compromises enrollees' ability to receive medically necessary services for their parity disorders.

Plans noted that reputable RTCs often have long waiting lists that contribute to the sense of urgency on the part of the parents to place their children in non-network facilities. Correspondingly, parents of SED/eating disorder children who feel that RTC is essential or medically necessary do not often fully understand why RTC benefits are not covered or, if covered, why RTC requests are denied.

b. There are an Insufficient Number of Structured Programs for the Treatment of Eating Disorders, Especially for Children and Young Adolescents

All seven plans surveyed provide treatment for eating disorders in varied settings including inpatient, intensive outpatient, partial hospitalization, and residential eating disorder treatment programs. One plan does not routinely use a residential eating disorder program because of questions regarding the efficacy of these programs. The scarcity of well-structured residential eating disorder programs—particularly those that have controlled supervised meals as part of the program—is a common concern raised by stakeholders. One plan reported that it had to send a child out of state to receive treatment from an appropriate program. Another plan identified the need for full-day partial hospitalization programs with supervised meals. One integrated plan (that does not routinely use residential eating disorder treatment programs) is developing an Eating Disorder Intensive Outpatient Program to meet the demands of its enrollees. As is true with regard to autism, health plans and parents report frustration with the lack of empirical evidence related to the causes and treatment of eating disorders.

c. A Significant Shortfall and Misdistribution of the Behavioral Health Workforce in California is Apparent, Especially in Child and Adolescent Psychiatry

All but one health plan surveyed expressed concern about the lack of child and adolescent psychiatrists throughout the state. These specialists often have long waiting lists, limiting access. Plans expressed a general concern about the lack of psychiatrists of all sub-specialties and other behavioral health service providers in the rural areas, particularly in areas of Northern California where the population has been growing rapidly. The survey team's review of the plans' geographic location of behavioral health providers, in conjunction with the residences/employment locations of enrollees, confirmed the shortage, and helped to identify specific counties where the need was greater.

Psychiatrists, especially child psychiatrists, often refuse to participate in managed care networks because of the system complexities. Due to the high demand for services, even when offered enhanced fee schedules by health plans, they see no reason to join plan networks. Thus, the shortage of providers

becomes further aggravated by an unwillingness to participate in plan networks.

Moreover, plans reported an increase in utilization of services as a result of increased benefits under parity, further straining the delivery system—especially in specialties and geographic areas where providers are scarce.

While individual plans use a variety of approaches to identify and attract available providers to participate in networks, a global approach may be necessary to address the low numbers of available providers.

d. Experiences With "Phantom Providers/Phantom Networks" Have Resulted in Delays and Frustration for Enrollees Seeking Appointments

Consumers and consumer advocate groups report that phantom providers are a significant issue. The term "phantom providers" (or "phantom network") is sometimes used to describe a plan's provider network listing of practitioners who do not have any slots open for new patients. Enrollees commonly access non-emergency services by requesting a list of providers (either from the plan customer service phone line or from a web site or print listing) and make calls to those providers to discuss services and make appointments. If enrollees call for an appointment and the providers have no openings, delays in initiation of treatment and enrollee frustration can occur.

Plans confirmed that phantom providers are a significant issue and may occur because:

- Providers' caseloads are full and they neglect to notify the plan(s) in which they participate.
- Providers' availability changes frequently, depending upon caseload.
- Providers limit the number of HMO patients they will accept due to low HMO fees.
- Plans maintain providers on their lists without regularly verifying the providers' availability/interest.
- High-demand specialties and rural areas have a scarcity of providers, filling appointments quickly or have long waiting lists.
- Providers die, retire, leave practices, or move, and plans may not receive notice.

e. There is Inconsistency in Plan Interpretation of Requirements and Associated Plan Operations in Support of After-Hours Services and Emergency Care Instructions

To appropriately address emergency and urgent situations, health plans must ensure that enrollees have access to care after regular business hours. All the health plans surveyed provided a hotline for contacting the plan. Once an enrollee has established a therapy relationship with a provider, however, that enrollee may attempt to contact the provider prior to or instead of contacting the plan in an emergency or urgent situation. Therefore, the plan must ensure that providers are available for after-hours emergencies, and provider messaging systems must provide clear instructions to patients about how to contact the provider and/or other sources of assistance in emergencies. Health plans must ensure that providers timely respond to routine messages, such as appointment requests.

Several plans commented that, while after-hours coverage is a standard practice among physicians (including psychiatrists), it has not consistently been a requirement among some other types of practitioners. Representatives of one plan reported that they received "pushback" from network psychologists, LCSWs and licensed marriage and family therapists about the plan's requirements for after-hours coverage and messaging.

4) Other Effects Of Implementing Parity Reported During Surveys

Direct observations during the surveys as well as interviews with health plan personnel revealed that the implementation of the parity legislation had both intended and unexpected effects, which served to strengthen and improve the delivery of behavioral health services.

1. Prior to the implementation of AB 88, standard benefit packages often required enrollees to pay higher co-payments for mental health services than for medical services. Because the intent of the legislation was to provide coverage for parity diagnoses "under the same terms and conditions applied to other medical conditions," the implementation of the legislation was expected to result in lower co-payments for the diagnoses covered under the parity legislation. An unexpected result, however, was that for a variety of reasons (e.g., challenges in defining some of the covered conditions, claims

processing system limitations, perceptions that differential co-payments would be unfair or cumbersome), some plans did not distinguish between parity and non-parity diagnosis and lowered co-payments and/or increased the number of allowed visits for all mental health diagnoses to the same levels as medical visits.

Others broadened their interpretation of SED to include even more children. At least one plan fully eliminated the distinction between children with an SED diagnosis and others and offered all children's services at the parity level. These changes are believed to have increased utilization of parity and non-parity services alike.

2. AB 88 broadened benefits for biologically based serious mental illness, autism, PDD, anorexia, and bulimia, and addressed a long-standing demand for these services.

3. The discussions and activity surrounding parity have increased recognition of serious mental health conditions throughout the healthcare industry.

4. Parity legislation has presented an opportunity to reduce the stigma of mental health conditions.

5. The focus on behavioral health disorders brought about by the implementation of AB 88 resulted in increased emphasis on the development of "best practice" guidelines for certain disorders, as well as increased training for health plan staff and providers.

6. The requirement for treatment of autism-related disorders prompted plans to increase communication and collaboration with regional centers. Some plans created specialist case management positions. In addition to developing effective working relationships with regional center service coordinators, these case managers developed increased sophistication about the role and responsibilities of schools in providing services to children with autism as part of the IEP.

7. Plans improved the structures and processes for accessing benefits, such as:

    a. Eliminating outpatient preauthorization for psychiatrist services, resulting in less paperwork for psychiatrists
    b. Increasing outreach to existing providers to widen plans' provider networks
    c. Implementing open-access programs with no need for prior authorization for routine outpatient care
    d. Implementing easier access to benefit information and network mental health providers by giving enrollees a single plan contact phone number

8. Plans expanded their provider networks. One plan reported an 18 percent increase in psychiatrists and a 26 percent increase in other mental health providers.

9. Many plans enhanced or developed case management programs to improve their capacity to effectively serve more seriously ill patients.

10. Medical management and treatment of parity conditions have improved as a result of:

    a. Training for plan staff and providers
    b. Developing and distributing clinical practice guidelines to ensure that care for conditions such as eating disorders, obsessive-compulsive disorders, panic disorders, and autism meets nationally recognized standards
    c. Increasing case management
    d. Increasing efforts to enhance communication between mental health providers and PCPs/other medical providers
    e. Increasing emphasis on identification and management of depression by PCPs
    f. Developing internal programs for treating eating disorders
    g. Increasing coordination with regional centers and the public school systems

11. Even though CD treatment is not included in parity, plans are identifying needs and providing more treatment to individuals who have both mental health and CD problems.

A P P E N D I X F

PROVISIONS OF THE MENTAL HEALTH PARITY ACT

The following is the text of the Parity Act.

§ 1374.72. Severe mental illnesses; serious emotional disturbances of children

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:
(1) Outpatient services.
(2) Inpatient hospital services.
(3) Partial hospital services.
(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Co-payments.
(3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:
(1) Schizophrenia.
(2) Schizoaffective disorder.
(3) Bipolar disorder (manic-depressive illness).
(4) Major depressive disorders.
(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism.
(8) Anorexia nervosa.
(9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age, according to expected

developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(g)(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, co-payments, or other cost sharing.

(h) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

§ 1300.74.72. Mental Health Parity

(a) The mental health services required for the diagnosis and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28. These basic health care services shall, at a minimum, include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists.

(b) A plan shall provide coverage for the diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are:

(1) acting within the scope of their licensure, and

(2) acting within their scope of competence, established by education, training and

experience, to diagnose and treat conditions set forth in Health and Safety Code section 1374.72.

(c) A diagnosis within the meaning of Health and Safety Code section 1374.72 shall be made in accordance with professionally recognized diagnostic criteria including, but not limited to, the diagnostic criteria set forth in the Diagnostic and Statistical Manual for Mental Disorders -- IV -- Text Revision (June 2000).

(d) A preliminary or initial diagnosis made by a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above, that an enrollee has one or more of the conditions set forth in Health and Safety Code section 1374.72, shall constitute the diagnosis for the length of time necessary to make a final diagnosis, whether or not the final diagnosis confirms the preliminary or initial diagnosis.

(e) "Pervasive Developmental Disorders" shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders—IV—Text Revision (June 2000).

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72, and for related health care services, as appropriate, upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:

(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee’s mental health services;

(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage;

(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;

(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:

(A) exchange of information,

(B) appropriate diagnosis, treatment and referral, and

(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders;

(5) the plan shall retain full responsibility for assuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized health care service plan to perform some or all of these activities.

(h) Nothing in this section shall be construed to mandate coverage of services that are not medically necessary or preclude a plan from performing utilization review in accordance with the Act.

(i) A plan shall include in its Evidence of Coverage or Combined Evidence of Coverage and Disclosure Form a list of mental conditions required to be covered pursuant to Health and Safety Code section 1374.72.

A P P E N D I X G

LIST OF ACRONYMS

Acronyms	Definition
ABA	Applied Behavioral Analysis
CD	Chemical Dependency
DMHC	California Department of Managed Healthcare
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
EOC	Evidence of Coverage
ER	Emergency Room
HF	Healthy Families program
HIPAA	Health Insurance Portability and Accountability Act
ICD-9 Code	International Classification of Diseases
IDEA	The Individuals with Disabilities Education Act
IEP	Individualized Education Program
LCSW	Licensed Clinical Social Worker
MBHO	Managed Behavioral Health Organization
OT	Occupational Therapy
Parity TAG	Parity Technical Assistance Guide
PCP	Primary Care Provider
PDD	Pervasive Developmental Disorders
PMG	Primary Medical Group
RTC	Residential Treatment Center
SED	Seriously Emotionally Disturbed
SLT	Speech and Language Therapy
SMI	Severe Mental Illnesses
The Rule	Title 28 of the California Code of Regulations
W & I Code	Welfare and Institution Code

A P P E N D I X H

LIST OF CONTRIBUTORS

A number of DMHC staff and contracted health care professionals contributed to the Mental Health Parity Focused Survey Project:

Name	Title
Barbara “Bobbie” Reagan	Assistant Deputy Director, HMO Help Center
Marcy Gallagher, R.N., M.P.A., J.D.	Chief, Division of Plan Surveys
Dan McCord, M.B.A.	Senior Health Care Service Plan Analyst
Ann Vuletich, M.P.H.	Staff Health Care Service Plan Analyst
Tom Gilevich	Counsel, HMO Help Center
Andrew George	Counsel, HMO Help Center
Lyndol Wilkins	Counsel, HMO Help Center

Name	Title
Rose Leidl, R.N., B.S.N.	Project Director, Surveyor
Bernice Young	Survey Manager
Daniel Kolb, Ph.D.	Surveyor
Sharon A. Shueman, Ph.D.	Surveyor
Ruth Martin, M.P.H., M.B.A.	Project Management, Surveyor
Patricia Allen, M.Ed.	Surveyor
Marshall Lewis, M.D.	Surveyor
Erick Davis, M.D., M.P.H., M.B.A.	Surveyor
Mark Leveaux, M.D.	Surveyor
Nikki Cavalier, L.C.S.W.	Surveyor